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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **LAUREL SCHOTT** **2929 Harvey Court** **Marina, CA 93933** **Registered Nursing License No. 427292** Respondent.	Case No. 2010-357 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about July 31, 1988, the Board of Registered Nursing issued Registered Nurse License Number 427292 to Laurel Schott ("Respondent"). The Registered Nursing License expired on July 31, 2008, and has not been renewed.

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JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing ("Board"), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code ("Code") unless otherwise indicated.

4. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

STATUTORY AND/OR REGULATORY PROVISIONS

6. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

. . .

7. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

COST RECOVERY

8. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of

the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

9. "Ativan" is the brand name for Lorazepam, a depressant and Schedule IV controlled substance as listed in Health and Safety Code section 11507(d)(16) and is a dangerous drug pursuant to Code section 4022. It is used for the treatment of anxiety associated with depression and/or acute alcohol withdrawal symptoms.

10. "Seroquel" is the brand name for Quetiapine Fumarate, a dangerous drug within the meaning of Code section 4022. It is an antipsychotic medication used to treat acute manic episodes associated with bipolar disorders or schizophrenia. Side-effects include hypotension, or lowering of blood pressure.

FACTUAL BACKGROUND

11. In August 2004, Respondent was hired as a per diem nurse at Pacific Grove Convalescent Hospital ("PGCH"), in Pacific Grove, California.

12. Respondent was on duty on October 29, 2006, as a charge nurse. Seven certified nurse assistants were also assigned to the floor. Patient J.L. was a 84 year old male, diagnosed with Alzheimer's and noted to have moderate cognitive deficits. Patient K.H. was a 53 year old male on Hospice care, diagnosed with schizophrenia, lung and brain cancer.

13. Respondent completed a "Medication Error" report October 30, 2006. She therein related that at 9:00 a.m., on October 29, 2006, she removed and dissolved in water the following four medications for K.H.: Senokot 2 tablets (laxative), Meclizine 25 mg (for nausea), Ativan 1 mg, and Seroquel 300 mg.[1] Without checking the photograph of the patient in the medication book with their prescribed medications and without checking the identification band on the patient's wrist, Respondent administered the above medications to J.L. instead of K.H., the patient for whom the medications had been prescribed.

[1] A nurse is required at all times follow the "five rights of medication administration:" right patient, right medication, right dose, right chart, and right route.

14. Respondent noted in a "Medication Error" report that it was later in the day she realized that the wrong medications had been given to J.L.

15. Prior to the morning of October 29, 2006, J.L.'s blood pressure had been normal. However, as a result of receiving the Seroquel he became severely hypotensive such that he had to be transferred to the Community Hospital of the Monterey Peninsula. His condition continued to deteriorate and he expired on November 1, 2006.

16. On April 12, 2007, Respondent by declaration gave a different scenario regarding the events on October 29, 2006. She admitted mixing in water the four medications that were intended for K.H., as referenced above in paragraph 13. However, in this scenario, Respondent related that before administering the medications she was called away to see another patient. She then gave the glass of water with the pre-mixed medications to the certified nurse assistant assigned to patient K.H. and instructed him to take the "cup of water" to K.H.'s room. Later on Respondent allegedly learned that the certified nurse assistant thought she had instructed him to take the "cup of water" to J.L., who reportedly drank all the "water."

17. Respondent acknowledged in her declaration that as a Registered Nurse, she was ultimately responsible for J.L. receiving the medications intended for K.H.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

18. Respondent is subject to disciplinary action for gross negligence pursuant to Code section 2761(a)(1), in that she failed to follow the standards of practice with regard to the administration of patient medications, and as a result Respondent gave J.L. the medications prescribed and intended for K.H. , as set forth in paragraphs 11 through 15, and 17, above.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence)

19. Respondent is subject to disciplinary action for gross negligence pursuant to Code section 2761(a)(1), in that she failed to follow the standards of practice with regard to the administration of patient medications and as a result a certified nursing assistant gave J.L. the medications prescribed and intended for K.H., as set forth in paragraphs 11 through 17, above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number RN 427292, issued to Laurel Schott.

2. Ordering Laurel Schott to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 1/25/10

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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